

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24E116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Andrew Residence		STREET ADDRESS, CITY, STATE, ZIP CODE 1215 South 9th Street Minneapolis, MN 55404	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure hazards were removed for R1 per their care plan and failed to provide R2 with the necessary supervision to prevent elopement after being care planned to require supervision in the community. These failures resulted in Immediate Jeopardy (IJ) for two of two residents when R1 attempted suicide after identified care plan interventions were not thoroughly implemented and when R2 left the facility multiple times without staff knowledge with an increase in suicidal ideation and in dangerously high temperatures. The Immediate Jeopardy (IJ) began on 7/16/26 when it was identified the facility failed to thoroughly implement R1's safety plan of a personal belonging search after recent history of suicidal ideations and attempts to overdose on medication. R1 procured a bottle of Tylenol and alerted staff that they ingested it, which R1 previously indicated was their plan to do; and continued when the facility failed to implement appropriate supervision for R2, who had suicidal ideations to jump off a bridge, eloped on multiple occasions and was unable to be found for extended periods of time. On 7/28/26 at 4:38 p.m., the administrator, director of nursing (DON), second floor program director, third floor program director, fourth floor program director, clinical development coordinator, clinical coordinator, evening nurse manager, nursing services coordinator, and, over the phone, the director of clinical services was notified of the IJ. The IJ was removed on 7/30/26, after it was verified, the facility implemented an acceptable removal plan. However, non-compliance remained at a lower scope and severity of D, no actual harm, with potential for more than minimal harm. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had diagnoses that included non-traumatic brain dysfunction, recurrent severe major depressive disorder without psychotic features, and autistic disorder. R1 had no cognitive impairment, had hallucinations, and demonstrated other behavioral symptoms not directed towards others which occurred 4 to 6 days during 7-day assessment period but less than daily. The MDS further identified R1 was independent with activities of daily living (ADLs). R1's Initial Treatment Plan dated 2/13/26, identified R1 had chronic passive suicidal ideation, with one noted escalation involving a plan (starving), daily visual hallucinations, low motivation for hygiene tasks, and mild anxiety related to adjustment. R1's Vulnerability Summary identified R1 had a pattern of drug/alcohol use or unprescribed use of over-the-counter drugs. R1 reported lack of urges to use and lack of funds kept R1 from thinking about purchasing substances. Interventions included discussing urges to use in weekly meetings and staff knowledge of historical use. The summary included R1 had severe psychiatric symptoms or cognitive deficits which significantly impaired judgment and functioning and displayed suicidal or self-injurious behaviors and/or thoughts which included previous suicide attempts of strangulation, overdose of medication, and starvation. R1 had reported daily passive suicidal ideation, with one instance of active suicidal ideation with a plan to (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 24E116 If continuation sheet Page 1 of 8

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	stressed, and more relaxed since a medication change. R1 indicated they had passive not active suicidal ideation and no plan or means.R1's care plan intervention dated 7/17/26, indicated R1 had funds in an online application and would review purchases weekly with the program manager. The program manager would provide additional prompts if R1 reported an increase in suicidal ideation. R1 would notify staff when a purchase was made, and staff would conduct a search of the purchased items to remove any items identified as a safety risk.R1's progress note dated 7/18/26 at 2:30 p.m., indicated R1 felt unsafe and reported they ingested a whole bottle of Tylenol and just now feeling the effects. Staff transported R1 to the emergency department around 1:00 p.m. and found one empty bottle of 100 capsules of Tylenol extra strength 500 mg (milligrams) each.R1's progress note dated 7/18/26 at 3:05 p.m., R1 came up to staff around 12:30 p.m. (7/8/26) and reported they hid a bottle of Tylenol in a bag of donuts when they ordered snacks and took the whole [bottle of Tylenol] on 7/16/26 around 10:00 p.m. (approximately 12 hours after hospital return.)R1's progress note dated 7/18/26 at 11:06 p.m., indicated R1 was admitted to the hospital due to elevated serum Tylenol levels and suicidal ideation.R1's progress note dated 7/19/26 at 10:31 a.m., indicated R1 was in the hospital with a one-to-one at bedside for safety.R1's progress note dated 7/22/26 at 9:36 a.m., indicated R1 was medically cleared and waiting for an open bed in the inpatient psychiatry area. R1 had a one-to-one for elopement and safety risk in the hospital.R1's Medicine Discharge summary dated [DATE], indicated R1 admitted [DATE] after intentional ingestion of approximately 100 tablets of acetaminophen 500 mg over 7/16/26 and 7/17/26. Initial R1's acetaminophen (Tylenol) blood level was 76 mcg/mL (therapeutic blood concentration is 10-30 mcg/mL; treatment decisions after an overdose are based on the time since ingestion and the Rumack-[NAME] nomogram rather than the blood level alone). R1's liver function tests and International Normalized Ratio (INR), a measure of the blood's ability to clot, remained within normal limits. R1 was treated with intravenous N-acetylcysteine (NAC), the antidote used to prevent acetaminophen-induced liver injury. Repeat acetaminophen level was less than 5 and AST/ALT (liver function blood tests) remained normal. R1 was medically stable for inpatient psychiatry transfer. Review of R1's record following Tylenol ingestion identified although the facility implemented and revised suicide prevention interventions following multiple psychiatric crises, the record demonstrated a recurring pattern of temporary stabilization followed by renewed suicidal ideation requiring additional emergency intervention. The record did not consistently identify how the effectiveness of previously implemented interventions including coping strategies was evaluated before modifying/discontinuing supervision or environmental safety interventions including supervision. During interview on 7/22/26 at 4:45 p.m., MHW-C stated R1 was usually quiet and stayed in their room a lot. R1 had continuous, passive suicidal ideation. MHW-C stated R1 was fascinated with afterlife and was sent to the hospital when they had an increase in suicidal ideation and then would be discharged from the hospital back to the facility and then sent back to the hospital. MHW-C stated she looked through R1's snacks on 7/16/26. MHW-C indicated she placed R1's tote on a desk, unzipped the bag, and moved items around to see two bags of donuts, three Mountain [NAME], and Sun Chips. MHW-C did not note any items of concern.During interview on 7/22/26 at 1:47 p.m., mental health worker (MHW)-A reviewed R1's plans to jump off a bridge and ingest eye drops on 6/14/26 and stated the facility moved R1's money to the facility to help track purchases but was unsure what date the intervention was added to the care plan. MHW-A reviewed R1's attempt to tighten yarn around their neck and was unsure where R1 got the yarn. MHW-A stated R1 came to him around 2:00 p.m. on 7/18/26 and indicated they had not been honest with staff about their level of suicidal ideation, had ingested Tylenol, and felt physically unwell. MHW-A stated R1 was on shift checks following hospitalization, staff followed R1's care plan (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24E116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Andrew Residence		STREET ADDRESS, CITY, STATE, ZIP CODE 1215 South 9th Street Minneapolis, MN 55404	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	by looking through R1's snacks after the purchase on 7/16/26, and he completed a room search on 7/18/26 after R1's report, finding an empty bottle of Tylenol and a bag of donuts with a resealable opening. MHW-A stated program managers were assigned to each resident, and the program manager worked with the resident to create an initial treatment plan using the resident's history, hospital records, and assessments completed by the social workers. The treatment plan identified resident vulnerabilities, which were discussed during weekly staff meetings, through emails, and by review of the care plan and progress notes. MHW-A stated check-ins were completed immediately when a resident returned from hospitalization. Shift checks were completed for nine shifts following any psychiatric-related hospitalization and included talking with the residents about suicidal ideation and symptoms. Location checks varied from every one hour to every eight hours and did not require conversation with the residents. During interview on 7/27/26 at 12:04 p.m., social worker (SW)-B staff completed vulnerability assessments and basic living skills assessments to determine if residents could be safe in the community. SW-B stated the vulnerability assessment was completed upon admission and then updated as needed. During interview on 7/23/26 at 12:47 p.m., registered nurse (RN)-A stated staff did not hold R1's supplies, and R1 kept knitting supplies in their room until after the incident when R1 tightened the yarn around their neck. RN-A indicated residents with a history of self-injurious behavior, such as strangulation, and increased suicidal ideation should not have rope-like items in their room, such as yarn, and staff should remove anything sharp or any other objects which could be used in the wrong way. During interview on 7/23/26 at 1:38 p.m., RN-B indicated residents with a history of strangulation should not have yarn in their room. RN-B indicated supplies which could be used for strangulation should be kept behind the staff desk, and residents could use identified supplies with supervision. RN-B stated she had not completed many bag searches but would put on gloves, open bag, and complete a visual inspection to ensure there were not any items which were stick-like or pointed. During interview on 7/22/26 at 3:32 p.m., licensed independent clinical social worker (LICSW)-A, who was the program manager for R1 and the program director for the floor where R1 resided, stated R1 was good the first few months at the facility and was honest and open about increased suicidal symptoms. R1 was readmitted to the facility on [DATE] after a hospitalization, which exceeded the facility's 18-day bed hold pol		